Governor's e-Health Care Quality and Patient Safety Board: Stakeholder Baseline Readiness, Perspective, and Buy-In

March 2006 Online Survey and Follow-up Interviews
A Summary of Findings

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BACKGROUND

The UW Population Health Institute, in partnership with the Medical College of Wisconsin and the Department of Health and Family Services, sent an online survey to 64 key informants. The goals of the survey were to:

1. Inform and educate key stakeholders regarding: Executive Order 129, the eHealth Care Quality and Patient Safety Board; electronic health records (EHR) and health information technology (HIT); and the e-health roadmap planning process.
2. Assess stakeholder health care and information priorities and perceptions of value or urgency regarding this initiative.
3. Assess stakeholder attitudes regarding state-wide (as opposed to local or national) interoperability and exchange.
4. Assess stakeholder views of appropriate and feasible roles for various sectors.
5. Gather stakeholder perceptions of Wisconsin's strengths, weaknesses, and opportunities (SWOT) relative to the adoption of EHR and HIT in the state.
6. Identify and recruit critical and willing participants for upcoming work groups.

The project team identified first tier survey recipients with the goal of reaching opinion leaders in various sectors. Online survey invitations were sent to individuals representing health care providers, purchasers, payers, employers, patients, public and private interests. A total of 37 individuals responded to the survey (response rate of 58%).

Follow-up interviews were conducted with a selected sub-set of survey respondents (n=16). These interviews were intended to supplement the survey data as follows:

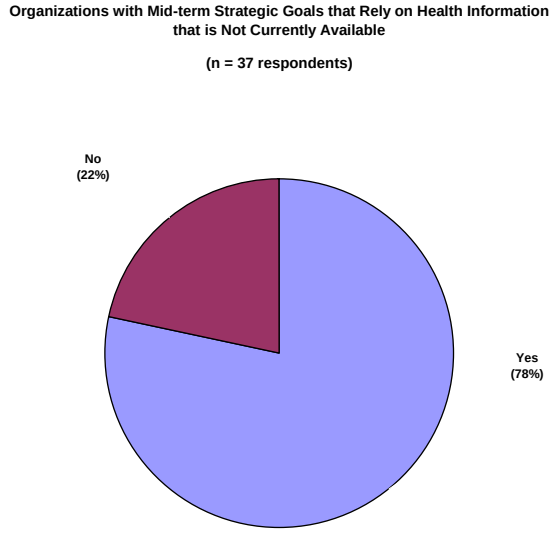
1. Further education and engagement of key stakeholders in the process;
2. Pursue qualitative responses with insight beyond what is available through the quantitative survey process; and
3. Develop an overall picture of baseline status, readiness, investment in, and support for the e-Health board goals and process.

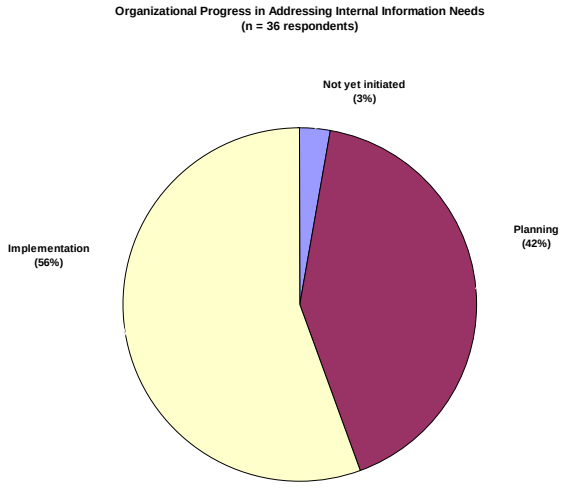
The following report provides a summary of the information garnered from the key informants who completed the online survey and follow-up interviews. Respondents are not identified with either their quantitative or qualitative information (comments).

Readiness, Planning, Implementation: Organizational Stage

Most respondents (78%) reported a need for attaining information that is not currently available to their organizations. As well, more than half are already in the implementation stage, as indicated in the charts below.

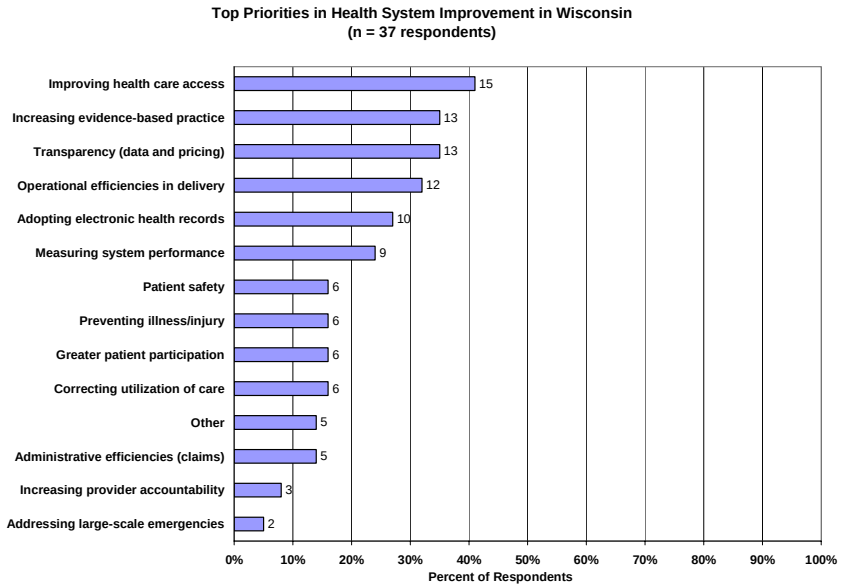
This said, one prominent executive in the provider arena noted "no information needs" beyond what is already being put in place within this respondent's system. This respondent acknowledged potential further needs for inter-operability across systems and sectors, but does not feel that this should be a top priority and does not consider it a "really pressing issue." This respondent also noted that "right now there is enough to fix with how organizations themselves operate internally, let alone at the interfaces."





PRIORITIES FOR HEALTH SYSTEM IMPROVEMENT IN WISCONSIN

Survey respondents exhibited a range of priorities. Each respondent was instructed to select up to three priorities from a list of 13 closed-ended responses and one open-ended response. As demonstrated in the graph below, the plurality (41%) selected *Improving health care access for un- and underinsured persons* while a close 35% selected *Transparency in quality data and cost/pricing* and *Increasing evidence-based practice.*



Other priorities identified by respondents include: reducing health care costs; re-connecting with health promotion and public health; and increasing consumerism in health care.

Of note, only 2 respondents selected *Detecting and responding to large scale emergencies* (e.g. outbreaks, terrorism) as among their top priorities. This may reflect the composition of the respondent group, approximately 75% of whom fall into the arena of personal health care services rather than what is more traditionally considered "public health." However, this response may also reflect the degree to which current leaders in the provider, payer, and purchaser community focus on this element.

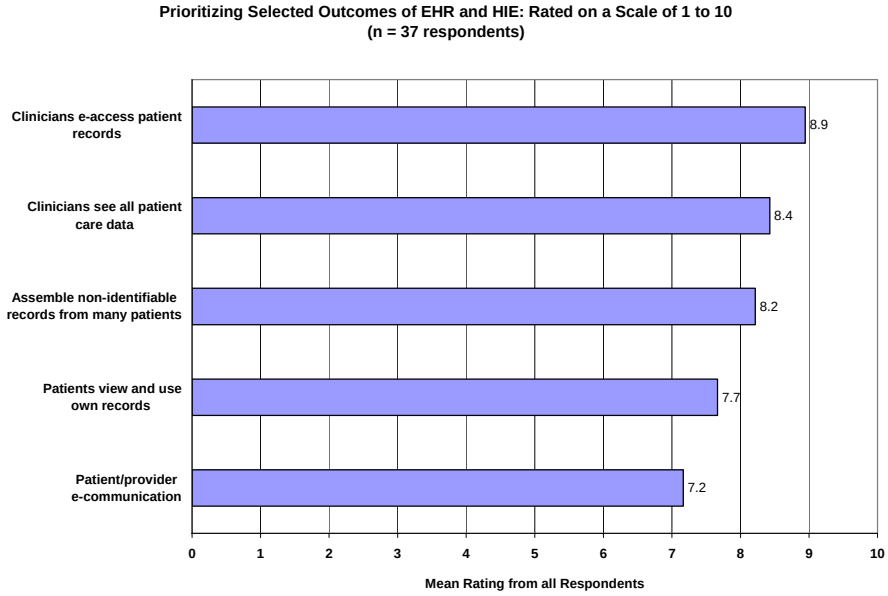
One respondent did voice a converse perspective – skepticism about clinical priorities in this endeavor. This respondent, citing SPHERE as an example, noted existing problems with performing most basic integration of public health program information, as well as a failure to reflect real health care workflow into the design of available products.

One respondent from the payer sector specifically added *Increasing consumerism in health care* as a top priority, going beyond the provided option intended to capture that notion (*Greater patient participation in health care decision-making*). This respondent wanted to emphasize the belief that consumers hold the key to controlling costs as well as a belief that top priority needs to be placed on making actionable information available for consumers to facilitate informed decisions about quality and cost issues.

Another respondent voiced a different spin on this concept. While most highly valuing quality and safety reporting to assist informed patient choices of plans and clinicians, this respondent noted that information exchange is secondary to the reality that quality, safety, and cost-efficacy are not rewarded in the current market place: "It may not be so critical to improve information flow until people have an incentive to act on that information."

PRIORITIES (RATING)

As indicated in the graph below, many respondents rated *Electronic communication between patients and providers* and *Patients viewing their own personal health records* low or lowest on the provided 1 to 10 scale (means of 7.2 and 7.7 vs. means ranging from 8.2 – 8.9).



In follow-up interviews, respondents noted the following rationales for such lower ratings:

- Only a small minority of the "lay population" has the interest/ability to do these.
- These advances would have the greatest impact *after* all systems are in place.
- There is not enough structure in place to make patients much better off now. There is little commonality about what appears, how it is used, and who is responsible for what. Nor is there common understanding of how to treat common conditions.
- Connectivity will work at the provider level first and foremost while patient ability to use this to their advantage will lag; even if patients use new information, most will probably still depend on their physician's expertise when making treatment decisions.
- Such communication has many risks and unknowns; it could slow down provider productivity by distracting providers with the noise of excessive patient e-mails.

However, one respondent in the payer sector noted that e-mail access to physicians can be "phenomenal" in improving appropriate use of care and self management.

Most respondents did endorse broad sharing of information among providers (mean ratings between 8.4 and 8.9 on the provided 1 to 10 scale). However, one provider-sector respondent noted that *clinicians seeing all information*—including information form

other clinicians/organizations—was not a priority but rather like a "Cadillac vs. a Chevy." In other words, it is a matter of convenience. This respondent noted that there are other ways to do this, we can already emulate other systems, and it does not merit the cost relative to other priorities.

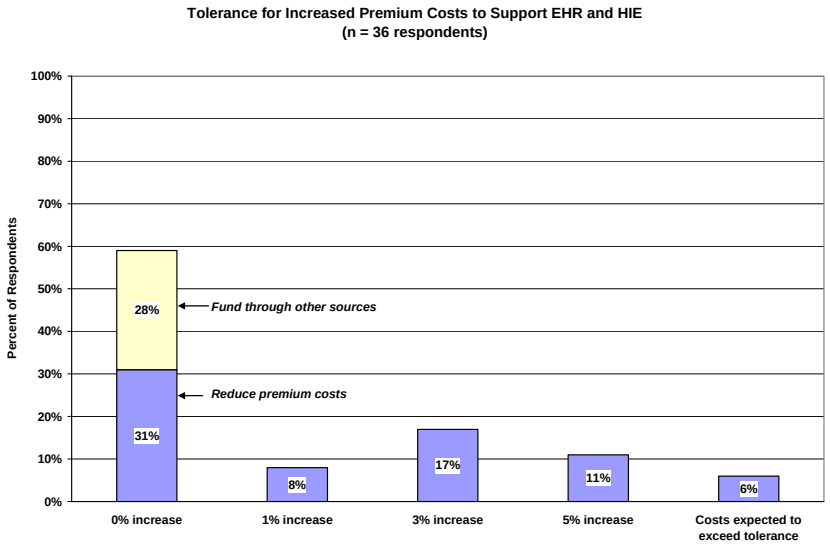
One employer-sector respondent further asserted: "don't let the perfect be the enemy of the good." A provider-sector respondent echoed this sentiment, urging focus on "key high value information"—not trying to do everything at once. This respondent further asserted that an ROI can be realized from each incremental step if it is directed toward the right problem.

TOLERANCE FOR ADDITIONAL PREMIUM COST

This question elicited a wide range of interpretations and responses. It was intended to understand where respondents believe the IT costs associated with e-health infrastructure would fall within the health care system as a whole, recognizing that resource investments inevitably will be needed both upfront in the form of hardware, software, human intelligence and personnel training, as well as ongoing expenses associated with system operation.

Key informants, however, variously interpreted the question from the perspective of a single sector or from the health care system as a whole. Some respondents, while acknowledging the costs of such a system, did not assign expenses to prices or premiums with the belief that such costs could be confined to existing capital budgets or other available reserves. Other respondents isolated the burden of the costs to those who are directly assigned the responsibility or burden of incurring them, and did not consider or dis-allowed any sense of inevitable building of such costs into overall price structures.

Respondents opinions regarding funding EHR and HIT through premium increases are summarized in the graph below.



The interview process allowed opportunities for respondents to elaborate on their answers. Respondent comments are provided below, along with the answer selected by the respondent:

1 percent increase

- The primary benefit of EHR/HIT is improving quality, therefore it isn't appropriate to think that all technological advancement needs to be (or can be) justified as cost-saving. There may be some additional costs to these benefits and pursuing them for cost-saving purposes only could curtail very worthwhile investments.

3 percent increase

- This amount should be sufficient, if spent correctly. This option is a mid-point—there will be some increase in costs up front and some of the increase will be passed on to consumers.
- Despite up front costs, there will be significant savings long-term; savings could approach 50% through standardizing care and increasing prevention.
- Computerizing health records is primarily the burden of the provider–paper records are not subsidized and EHR is a natural evolution of the paper record, albeit a substantial investment. EHR technology purchase is comparable to purchasing surgical and office supplies.

5 percent increase

- This amount is a guestimate, but given huge upfront costs for physician groups, hospitals, etc., it is a reasonable amount.

No increase – Should be funded by other sources

- Premiums imply insurance payer only. Other, more universal, funding sources should be secured.
- Smaller providers will have higher per-patient costs for such a system. Considering EHR and HIT a social good, we should aim to even out the costs through cross-subsidization.
- Currently, the health care premium burden on employers and individuals in Wisconsin is maxed out, which negatively impacts Wisconsin's competitiveness relative to other states. There is no room for premiums to absorb additional costs.
- Federal funds would be a more appropriate funding source as e-activities cross state boundaries and many employers are multi-state.
- No other industry expects a surcharge to pay for technology that can only help improve its products and services.
- There is a lot of capital in the industry (providers, insurers, payers, commercial carriers, health plans, medical groups, and hospitals). The cost burden should fall on industry rather than purchasers and consumers.

- Technological improvement is an allocation choice. That said, there have been decades of underinvestment in technology in this industry so it could be hard to make up the costs *only* within the delivery system. Targeted federal assistance could be warranted for organizations that have limited access to capital (i.e., critical access hospitals/clinics, small clinics, etc.)

No increase - Should reduce premiums

- Regarding infrastructure/up-front costs (vs. future benefits) – from a payer-sector respondent: Large hospitals and clinics have sizeable capital budgets, and if they feel this is high enough priority, they will get it done. Provider reimbursement rates are higher in WI than in many other states, so there should be revenue available for technological advancements.
- Increasing service, eliminating waste, and making things safer are the responsibility of the provider (vs. consumer). Moreover, increasing competition and evolving technology will increase market share for those who "jump in"—those who don't will be left behind.

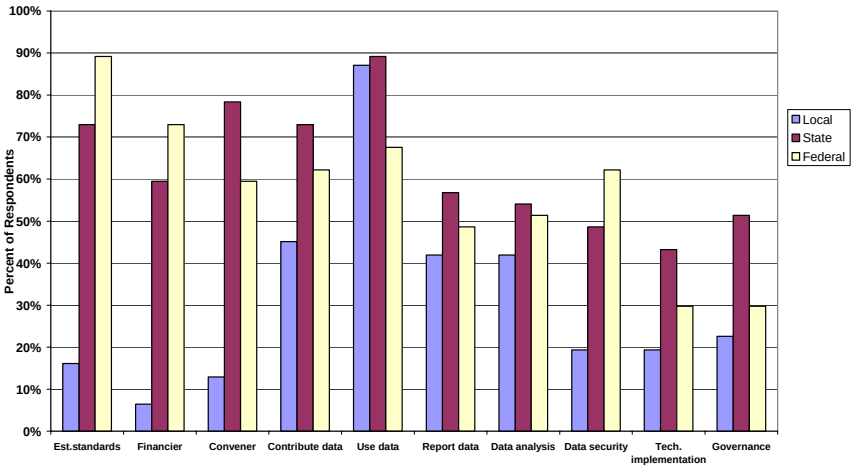
An employer sector respondent acknowledged the need for up-front investments with an expectation of later cost reductions. This respondent also voiced an expectation that the public sector payers support their fair share of the technology's adoption so these costs are not loaded onto private insurance.

Finally, one respondent from the provider sector responded that the costs will exceed what payers and purchasers will tolerate. This respondent asserted that the kind of investments being contemplated will require either cutting access or savings through reductions in variation and use of evidence-based medicine.

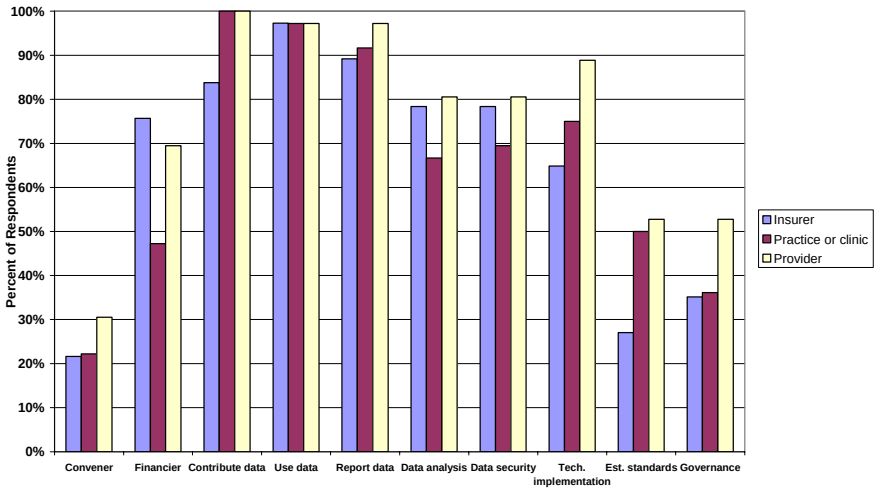
APPROPRIATE AND FEASIBLE STAKEHOLDER ROLES

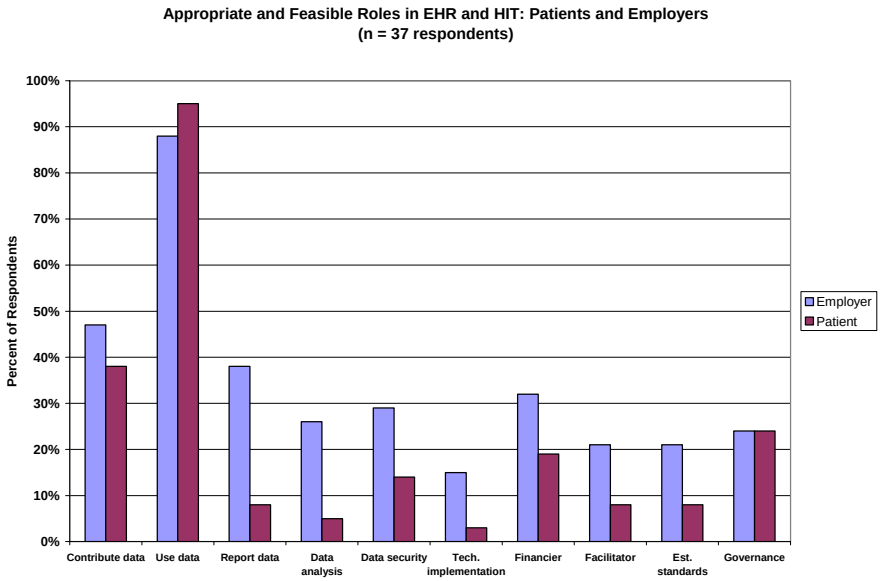
Respondents were asked to assign appropriate and feasible roles to several potential stakeholder sectors, including: federal, state, and local government, payers, employers, providers, and patients/consumers. Respondents were given several options from which to select roles. The graphs below reflect respondents' views of governmental entities (local, state, and federal); non-government entities (insurers, health care providers, and practices or clinics); and patients/consumers and employers.

Appropriate and Feasible Roles in EHR and HIT: Government Entities
(n = 37 respondents)



Appropriate and Feasible Roles in Adopting EHR and HIT: Non-Governmental Entities
(n = 37 respondents)





A number of respondents shared comments about the stakeholders included in the survey and the selection of roles provided:

- Lab vendors should be considered submitters of data in this system.
- University experts should have a role separate from the University as payer or provider.
- Consumer/Community, as distinct from "patient," should have a role.
- State government is not a realistic financier—not enough money to make a dent in individual systems that require $50-$100 million each.
- Ideally, all payers (including the state) should help finance these efforts. However, realistically, the state is unlikely to have the funds to contribute significantly—especially considering low MA and BadgerCare reimbursement rates.
- To successfully achieve the scale of change proposed here, it is critical to have broad inclusion and buy-in from a wide variety of stakeholders.
- It is critical for the state to stay involved in this project as a convener/facilitator. This gives legitimacy and helps to further a statewide process.

One respondent took a broad and system-reform-focused perspective when considering the roles for various entities and sectors. In particular, this respondent stated the hope, in a reformed financing system, that employers need not and should not be major planners, purchasers, or providers of care in the future, and thus need not have a major role in the current initiative.

Interpretation of 'Governance'

Early in the interview process, one respondent asserted a need to distinguish between a formal governance role over information systems and a more informal concept of an "advisory role" that could have more opportunities for membership and participation. Throughout the interview process, we queried respondents to identify potentially differing interpretations of the concept of "governance." The following interpretations were shared:

- Formal governance involves a public/private partnership, charged with setting standards; "There are many ways to do this, and none of them will be easy."
- Formal governance should be provider driven since it is likely to be largely provider funded. However, there is a role for all stakeholders to advise and hasten the diffusion of this technology. (From a provider sector representative)
- Considering governance in the sense of "new governance" vs. traditional, command and control government, there is a role for a very wide variety of stakeholders in the decision-making, planning process.
- The appropriate concept of formal governance depends on the parties driving the initiative. If this endeavor is government driven (vs. privately driven like WHIO) an advisory sense may be more appropriate.
- Although an elected board or some other formal body would not be appropriate for steering an endeavor like this, it is important to have a mechanism to give a broad group of stakeholder input.
- Formal governance involves setting standards, as lack of consistent standards stands as one impediment to progress. This requires federal leadership.

Regulatory Role of State and/or Federal Government

We followed the discussion of governance by questioning respondents on their views of the regulatory role of government in this arena. Most respondents asserted the need for a strong federal role that takes precedence over any state-level activity wherever there is a need for regulation. At the same time, respondents' overall assessment of the regulatory role varied. For example:

- The federal government has already staked out a number of areas for which to develop policies (i.e., interoperability). Determining state role here is difficult.
- State and federal governments should only regulate around standardization of project specifications. They should also lift some privacy regulations through HIPAA to account for these new uses of data. It will be very important to avoid too much regulation.

Many respondents explicitly asserted a desire for "as little regulation as possible." Respondents elaborated on this notion as follows:

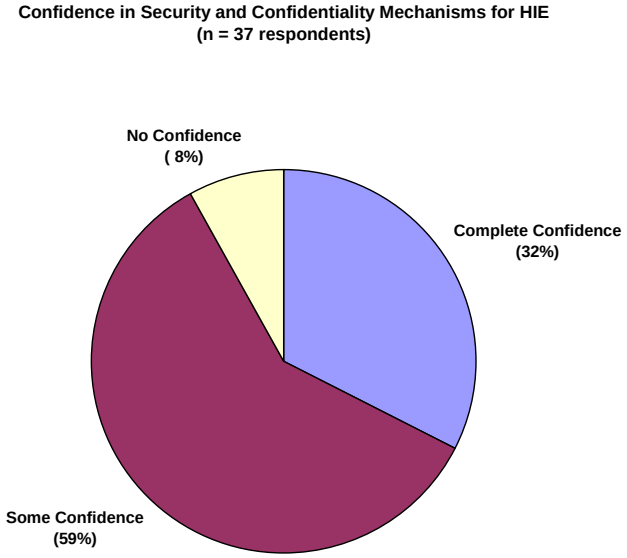
- It is most important for all stakeholders to agree on the rules of the system; you can't regulate your way to a good system. Once we have agreed upon rules, some level of regulation/enforcement is appropriate.
- The most important role for government is setting standards that are consistent across the board. Federal/state interaction here is important.
- Over-regulation could slow this process; we need provider systems to drive innovation and change, but unified standards would help.
- System would be best if run by a quasi-public (vs. government) entity.
- Once standards are set, skeptical that there is a need for significant regulation. When one looks to other areas where technological advances have been very successful (i.e, ATM networks) there isn't much regulation.

Respondents repeatedly affirmed the need for consistent standards at the national level. At the same time, one respondent voiced a desire to "keep it closer to the action with

those directly affected," while another voiced concern that national standards may be too slow in coming and that the State needs to move ahead with timely action. Another respondent further asserted a sentiment that seemed to underlie several others' perspectives: Healthcare is a local issue. Adding additional layers increases complexity. Federally required uniform standards for data exchange that allow for local flexibility in implementation are preferable. WHIO provides a good model for getting things done.

PERSONAL CONFIDENCE IN EHR

The chart below illustrates respondents' reported a high degree of confidence in the current and potential electronic system. Responses to this question likely reflect the composition of our respondent group (dominated by industry stakeholders). National surveys of lay consumers and patients suggest that responses would likely vary significantly were this group represented more broadly in this survey and interview process.



The information here, then, provides a view of the potential opinion gap that exists between industry professionals and the lay public. This would suggest a large role for public education and outreach, as well as engagement of consumer and privacy advocates, throughout the roadmap planning process.

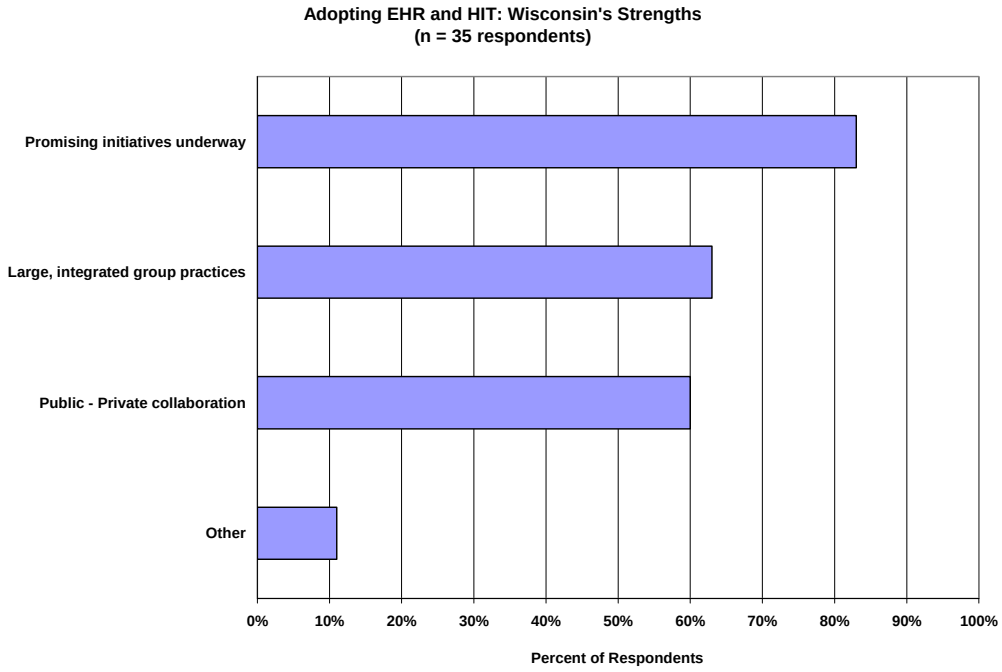
Even those respondents who reported that they are only *somewhat confident* reported a high degree of comfort with the system when further questioned during follow-up interviews. Comments received through the interview process fell within the following major points:

- Any concerns are "entirely solvable." While there are possible breaches in EHR, the same goes on in paper records. This respondent doesn't believe that the system requires *complete confidence* as long as there is "significant confidence."

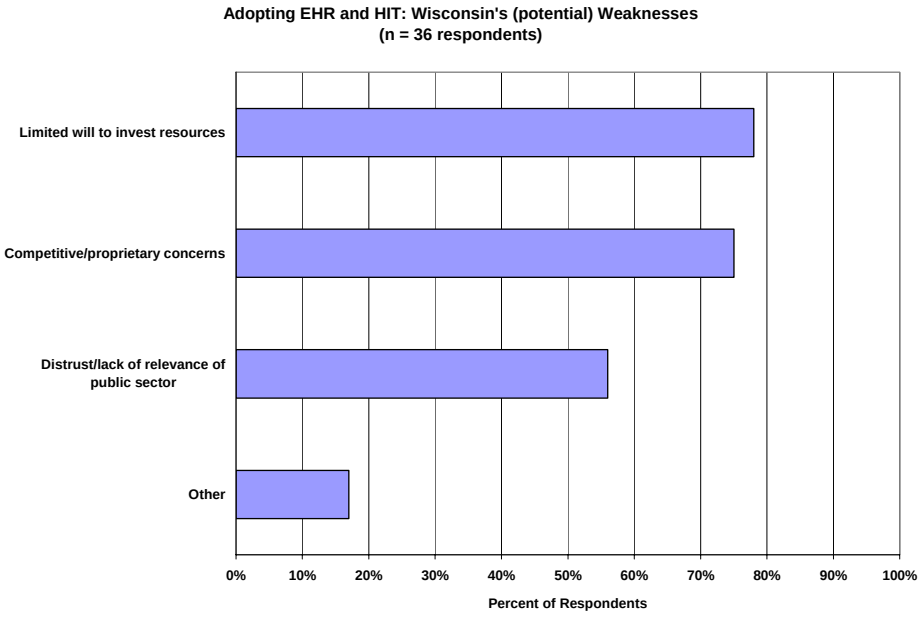
- *Complete confidence* may be a little bit of an overstatement; but generally HIPAA/security concerns are overplayed.
- Things happen, but overall confident that appropriate safeguards are/will be in place. Concerns over safety and security can bog down the process and keep us from moving forward.
- Although there are real issues of concern, adequate technology exists for protection of information as long as it is clear what should be protected.

WISCONSIN'S STRENGTHS, WEAKNESSES, AND OPPORTUNITIES

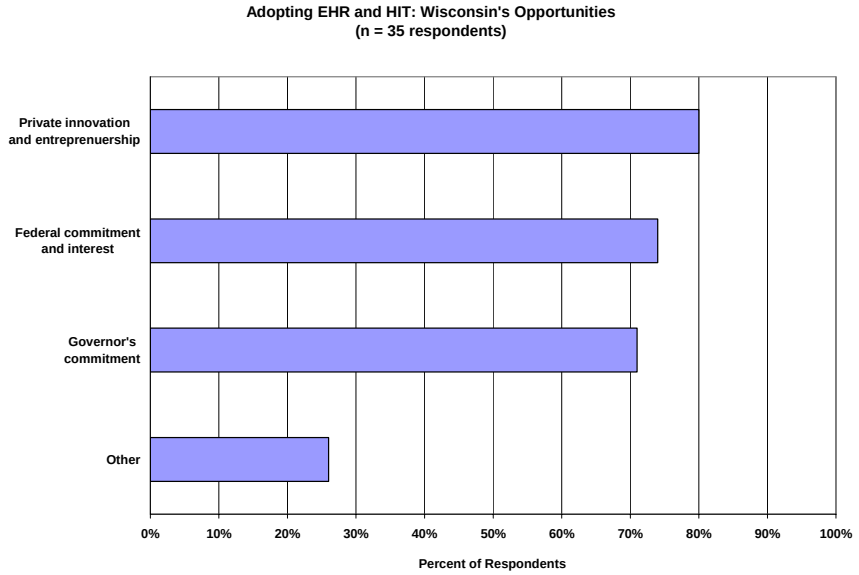
In the online survey, respondents were asked to share their opinions about Wisconsin's strengths, weaknesses, and opportunities in adopting EHR and HIT. The graphs below portray Wisconsin's landscape relative to these technological advancements, as perceived by the individuals who completed the survey.



Other strengths identified by respondents include: Wisconsin's health care providers financial situation is generally strong; EPIC's presence in the state; educated health consumers; Quality hospital discharge data; and recent private sector collaborations.



Other weaknesses identified by respondents include: state mandated reporting to a data bank that went nowhere and created a track record of doing nothing with available data; lack of connectivity standards; "WHA's franchise over hospital discharge data set"; and a late start.



Other opportunities identified by respondents include: state facilitation that includes small rural perspective; state and federal funding; expanding stakeholders to include more patients, community, consumers, and privacy advocates; establishing recognition by the Governor for providers who are blazing the trail (e.g., and annual award ceremony); leadership of business and health systems; maintaining trust through involvement for tribal health systems.

The interview process enhanced the SWOT analysis portion of the online survey by allowing respondents to clarify or elaborate on their answers. Comments included:

- Wisconsin is a leader in reporting and using clinical data, evidence-based measures, and public reporting to spur improvement (e.g., through the WI Collaborative for Healthcare Quality, WHIO, and Checkpoint). In addition, several in the physician sector are becoming leaders in the quality and efficiency movement.
- There is a risk that multiple initiatives could result in redundant costs.
- "Black box" commercial entities distract from legitimate ventures.
- Claims information from WHIO needs to be supplemented by true clinical data that will allow valid tracking of quality clinical indicators. Claims data alone do not have needed content, particularly pertaining to outcomes. For this reason, WI needs to advance in the use of EHR and the adoption of chronic disease registries by primary care practices.

Some respondents also outlined current activities and provided examples of successes in their own arenas. One respondent particularly noted the success of web-based pre-authorization, eligibility lookup, and predictive modeling of patients. Another noted the important role for professional societies in supporting smaller and rural practices in the arena of pay-for-performance.

SUMMARY PERSPECTIVES: eHEALTH INITIATIVE

Most respondents expressed strong interest in and support for the goals and anticipated work of the Governor's e-Health Board. Many reported intentions to participate in the work group process and also provided names of colleagues that they recommended for inclusion in the work groups.

Many respondents were uncertain about how this initiative relates to existing projects, particularly the Wisconsin Health Information Organization (WHIO). It appears that the Board will need to clearly outline the distinct, complementary, and value-added role that it and the Action Planning process plays in relationship to existing private sector endeavors. This is particularly true with regard to interoperability, the relationship across sectors, and the integration of information in the health care delivery arena with data in the public health arena. The needs and potential benefits of such cross-sector information are not yet well-understood.

Many respondents provided several closing thoughts either to add something that did not come through elsewhere in the survey and interview or to further reinforce a deeply held principle. These are summarized below:

- Somewhat confident that the state will ensure a role for small, rural hospitals and "keep them from being trampled" by bigger hospitals.
- Aware of some pilot projects where a large insurer provides patient data directly to ER doctors at point of care.
- If we are moving towards a model of consumer driven health care, it is important for patients and consumers to be heavily involved in development of new

technology. That is, they should be considered more than simply users of data; they should contribute to decisions of what data should be available.

- Worth noting that self-insured employers are not subject to state-level mandates.
- One important result/side-effect of transitioning to EHR/HIT could be increased guidance (national) for evidence-based practice standards, outcome measurement tools and protocols for measuring outcomes. This is very important!
- While private innovation and entrepreneurial activity are critical (and have been successful) in efforts to implement EHR/HIT the government has a unique role in determining *what* needs to be done in these areas.

Finally, there were a number of more skeptical comments about the potential role for the State generally and the eHealth Board specifically in this arena. One respondent noted a belief that the transition to EHR/HIT is a federal responsibility and inter-state issue, and that it would perhaps be "hubris" for the state to insert itself too deeply in this process.

Another respondent provided perhaps the most skeptical perspective of all when asserting the concern that this may all amount to "technology applied to bad systems." This respondent also described a more cynical view of the federal initiatives currently underway, calling them "essentially an unfunded mandate."

This respondent noted that, with some of the potential requirements regarding interoperability, system interface, and other elements, the private sector hasn't picked up these functions already because there is not an obvious ROI. The system being contemplated requires massive capital expenditures that may threaten the financial viability of already weak systems.
This respondent closed by noting, in reference to the Governor's E-Health Board: "I wish them luck, but I'm not sure how consequential this is."

Question Text and Answer Option

1. What are your three top priorities for health system improvement in Wisconsin?

Correcting over- or under-utilization of care
Transparency in quality data and cost/pricing
Improving health care access for un- and underinsured persons
Greater patient participation in health care decision-making
Increasing provider accountability (e.g., report cards, pay for performance)
Administrative efficiencies in claims processing and payment
Operational efficiencies in health care delivery
Capturing opportunities to prevent illness or injury (e.g., immunization)
Detecting and responding to large scale emergencies
(e.g., outbreaks, terrorism)
Measuring and addressing health system performance
(e.g., disparities, quality)
Adopting electronic health records
Increasing evidence-based practice
(includes inappropriate variation or redundant care)
Measure, report on, and improve patient safety
Other, please specify

2. Do any of your organization's mid-term strategic goals (i.e., 5-year horizon) rely on electronic health information beyond that already available?

Yes
No

3. If yes, please briefly describe these goals and needs.

4. What stage is your organization in addressing its health information needs?

Not yet initiated
Planning
Implementation

5. How much potential do you think electronic advances hold for improving the efficiency, speed, and accuracy of health care communications (e.g., reporting lab results, submitting payment claims)? (1 - 10 scale)

6. How important is it that clinicians have ready access to their own patient records electronically? (1 - 10 scale)

7. How important is it that clinicians can see all information pertaining to a patient's care, including information from other clinicians'/organizations' records? (1 - 10 scale)

8. How important is it that patients can view and use their own personal health record to manage their health and health care? (1 - 10 scale)

9. How important is it that non-identifiable records from many patients are assembled to monitor and improve quality, safety, and cost-efficacy across providers, facilities, and sectors? (1 - 10 scale)

10. How important is it to allow electronic communication between patients and providers? (1 - 10 scale)

11. Wisconsin's average annual cost of Employment-Based Health Insurance in 2003 was $3,749 for single coverage and $9,562 for family coverage. How much *additional* premium cost would you tolerate to support a system intended to achieve the functions listed in questions 5-10 above?

None; These measures should reduce premium costs
None; These measures should be funded through other sources
1% increase
3% increase
5% increase
I expect the cost to exceed what payers and purchasers will tolerate

12. Please add any additional comments about your tolerance for additional premium costs.

13. What role(s) do you envision for the federal government?

Convenor/Facilitator
Financier
Contributor of data
User of data
Data reporting
Data analysis
Data security/Confidentiality
Technology implementation
Establishing standards, policies, etc.
Governance

14. What role(s) do you envision for state government?

Convenor/Facilitator
Financier
Contributor of data
User of data
Data reporting
Data analysis
Data security/Confidentiality
Technology implementation
Establishing standards, policies, etc.
Governance

15. What role(s) do you envision for local government?

Convenor/Facilitator
Financier
Contributor of data
User of data
Data reporting
Data analysis
Data security/Confidentiality
Technology implementation
Establishing standards, policies, etc.
Governance

16. What role(s) do you envision for health care provider organizations?

Convenor/Facilitator
Financier
Contributor of data
User of data
Data reporting
Data analysis
Data security/Confidentiality
Technology implementation
Establishing standards, policies, etc.
Governance

17. What role(s) do you envision for physician practices and clinics?

Convenor/Facilitator
Financier
Contributor of data
User of data
Data reporting
Data analysis
Data security/Confidentiality
Technology implementation
Establishing standards, policies, etc.
Governance

18. What role(s) do you envision for health plans and insurers?

Convenor/Facilitator
Financier
Contributor of data
User of data
Data reporting
Data analysis
Data security/Confidentiality
Technology implementation
Establishing standards, policies, etc.
Governance

19. What role(s) do you envision for employers?

Convenor/Facilitator
Financier
Contributor of data
User of data
Data reporting
Data analysis
Data security/Confidentiality
Technology implementation
Establishing standards, policies, etc.
Governance

20. What role(s) do you envision for patients?

Convenor/Facilitator
Financier
Contributor of data
User of data
Data reporting
Data analysis
Data security/Confidentiality
Technology implementation
Establishing standards, policies, etc.
Governance

21. Please add any additional comments about the roles of these (and other) stakeholders in adopting electronic health records and health information exchange in Wisconsin.

22. Efficient exchange of clinical information requires standards and policies related to the formatting, transmission, storage, privacy, security, and use of personal health information. Do you believe such standards should be established on a statewide, local, or national basis?

Statewide
Local
National
Other, please specify

23. Why?

24. What are Wisconsin's strengths in adopting electronic health records and health information exchange?

Several promising initiatives already underway
Majority of health care provided by large, integrated group practices
History of collaboration between public and private sector in this area
Other, please specify

25. What are Wisconsin's (potential) weaknesses in adopting electronic health records and health information exchange?

Competitive/proprietary concerns among providers, payers, and purchasers
Distrust or lack of perceived relevance of public sector as a partner
Limited will to invest sufficient resources (financial)
Other, please specify

26. What opportunities could help Wisconsin adopt electronic health records and health information exchange?

Governor's commitment through the e-Health Council
Federal commitment and interest
Innovation and entreprenuership already underway in the private sector
Other, please specify

27. Please provide any additional comments about Wisconsin's strengths, weaknesses, and opportunities as it moves towards adopting electronic health records and health information exchange.

28. How much confidence do you have in available mechanisms to assure security and confidentiality of individual level health information exchanged in broader networks?

No confidence; I am uncomfortable having my own information exchanged
Some confidence; I am somewhat comfortable having my own information exchanged
Complete confidence; I am very comfortable having my own information exchanged

29. Workgroups will be formed to address each of the specific charges outlined in Executive Order 129. Activities will take place between May and October, 2006. Please nominate yourself or others for any of the workgroups listed below. *Please include an e-mail address or phone number for each nominee.*

30. Would you like to be added to our communications list to learn more about this initiative as it progresses? *If yes, please enter your contact information below.*

31. A Kickoff Summit is scheduled for May 5, 2006 at the Fluno Center in Madison. Do you plan to attend this summit?

32. Please add any additional comments about this survey or Wisconsin's transition to electronic health records and health information exchange.